Name	: **Ms. RAMYA S**		
PID No.	: MED112132425	**Register On**	: 29/03/2024 9:26 AM
SID No.	: 1802410133	**Collection On**	: 29/03/2024 9:36 AM
Age / Sex	: 33 Year(s) / Female	**Report On**	: 29/03/2024 6:57 PM
Type	: OP	**Printed On**	: 14/05/2024 5:22 PM
Ref. Dr	: **MediWheel**		

medall DIAGNOSTICS

Investigation	Observed Value	Unit	Biological Reference Interval
BLOOD GROUPING AND Rh TYPING (EDTA Blood/*Agglutination)*	'B' 'Positive'		

INTERPRETATION: Reconfirm the Blood group and Typing before blood transfusion

Complete Blood Count With - ESR

Haemoglobin (Whole Blood - W/*Spectrophotometry)*	**11.4**	g/dL	12.5 - 16.0
Packed Cell Volume(PCV)/Haematocrit (Whole Blood - W/*Derived from Impedance)*	**34.9**	%	37 - 47
RBC Count (Whole Blood - W/*Impedance Variation)*	4.26	mill/cu.mm	4.2 - 5.4
Mean Corpuscular Volume(MCV) (Whole Blood - W/*Derived from Impedance)*	81.9	fL	78 - 100
Mean Corpuscular Haemoglobin(MCH) (Whole Blood - W/*Derived from Impedance)*	**26.9**	pg	27 - 32
Mean Corpuscular Haemoglobin concentration(MCHC) (Whole Blood - W/*Derived from Impedance)*	32.8	g/dL	32 - 36
RDW-CV (Whole Blood - W/*Derived from Impedance)*	13.6	%	11.5 - 16.0
RDW-SD (Whole Blood - W/*Derived from Impedance)*	38.98	fL	39 - 46
Total Leukocyte Count (TC) (Whole Blood - W/*Impedance Variation)*	7600	cells/cu.mm	4000 - 11000
Neutrophils (EDTA Blood/*Impedance Variation & Flow Cytometry)*	72.1	%	40 - 75
Lymphocytes (EDTA Blood/*Impedance Variation & Flow Cytometry)*	**18.1**	%	20 - 45

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Investigation	Observed Value	Unit	Biological Reference Interval
Eosinophils (EDTA Blood/*Impedance Variation & Flow Cytometry)*	2.2	%	01 - 06
Monocytes (EDTA Blood/*Impedance Variation & Flow Cytometry)*	7.3	%	01 - 10
Basophils (EDTA Blood/*Impedance Variation & Flow Cytometry)*	0.3	%	00 - 02
INTERPRETATION: Tests done on Automated Five Part cell counter. All abnormal results are reviewed and confirmed microscopically.			
Absolute Neutrophil count (Whole Blood - W/*Impedance Variation & Flow Cytometry)*	5.48	10^3 / µl	1.5 - 6.6
Absolute Lymphocyte Count (Whole Blood - W/*Impedance Variation & Flow Cytometry)*	**1.38**	10^3 / µl	1.5 - 3.5
Absolute Eosinophil Count (AEC) (Whole Blood - W/*Impedance Variation & Flow Cytometry)*	0.17	10^3 / µl	0.04 - 0.44
Absolute Monocyte Count (Whole Blood - W/*Impedance Variation & Flow Cytometry)*	0.55	10^3 / µl	< 1.0
Absolute Basophil count (Whole Blood - W/*Impedance Variation & Flow Cytometry)*	0.02	10^3 / µl	< 0.2
Platelet Count (Whole Blood - W/*Impedance Variation)*	261	10^3 / µl	150 - 450
MPV (Whole Blood - W/*Derived from Impedance)*	8.1	fL	8.0 - 13.3
PCT (Whole Blood - W/*Automated Blood cell Counter)*	0.21	%	0.18 - 0.28
ESR (Erythrocyte Sedimentation Rate) (Whole Blood - W/*Automated - Westergren method)*	17	mm/hr	< 20

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The results pertain to sample tested.

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Investigation	Observed Value	Unit	Biological Reference Interval
BUN / Creatinine Ratio	9.8		6.0 - 22.0
Glucose Fasting (FBS) (Plasma - F/*GOD-PAP*)	82.1	mg/dL	Normal: < 100 Pre Diabetic: 100 - 125 Diabetic: >= 126

INTERPRETATION: Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level.

Glucose, Fasting (Urine) (Urine - F/*GOD - POD*)	Negative		Negative
Glucose Postprandial (PPBS) (Plasma - PP/*GOD-PAP*)	105.5	mg/dL	70 - 140

INTERPRETATION:
Factors such as type, quantity and time of food intake, Physical activity, Psychological stress, and drugs can influence blood glucose level. Fasting blood glucose level may be higher than Postprandial glucose, because of physiological surge in Postprandial Insulin secretion, Insulin resistance, Exercise or Stress, Dawn Phenomenon, Somogyi Phenomenon, Anti- diabetic medication during treatment for Diabetes.

Urine Glucose(PP-2 hours) (Urine - PP)	Negative		Negative
Blood Urea Nitrogen (BUN) (Serum/*Urease UV / derived*)	**6.3**	mg/dL	7.0 - 21
Creatinine (Serum/*Modified Jaffe*)	0.64	mg/dL	0.6 - 1.1

INTERPRETATION: Elevated Creatinine values are encountered in increased muscle mass, severe dehydration, Pre-eclampsia, increased ingestion of cooked meat, consuming Protein/ Creatine supplements, Diabetic Ketoacidosis, prolonged fasting, renal dysfunction and drugs such as cefoxitin, cefazolin, ACE inhibitors, angiotensin II receptor antagonists,N-acetylcysteine, chemotherapeutic agent such as flucytosine etc.

Uric Acid (Serum/*Enzymatic*)	4.50	mg/dL	2.6 - 6.0

Liver Function Test

Bilirubin(Total) (Serum/*DCA with ATCS*)	1.04	mg/dL	0.1 - 1.2
Bilirubin(Direct) (Serum/*Diazotized Sulfanilic Acid*)	0.18	mg/dL	0.0 - 0.3

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Investigation	Observed Value	Unit	Biological Reference Interval
Bilirubin(Indirect) (Serum/*Derived)*	0.86	mg/dL	0.1 - 1.0
SGOT/AST (Aspartate Aminotransferase) (Serum/*Modified IFCC)*	19.30	U/L	5 - 40
SGPT/ALT (Alanine Aminotransferase) (Serum/*Modified IFCC)*	18.4	U/L	5 - 41
GGT(Gamma Glutamyl Transpeptidase) (Serum/*IFCC / Kinetic)*	17.00	U/L	< 38
Alkaline Phosphatase (SAP) (Serum/*Modified IFCC)*	58.30	U/L	42 - 98
Total Protein (Serum/*Biuret)*	6.95	gm/dl	6.0 - 8.0
Albumin (Serum/*Bromocresol green)*	3.9	gm/dl	3.5 - 5.2
Globulin (Serum/*Derived)*	3.05	gm/dL	2.3 - 3.6
A : G RATIO (Serum/*Derived)*	1.28		1.1 - 2.2
Lipid Profile			
Cholesterol Total (Serum/*CHOD-PAP with ATCS)*	**217.70**	mg/dL	Optimal: < 200 Borderline: 200 - 239 High Risk: >= 240
Triglycerides (Serum/*GPO-PAP with ATCS)*	81.90	mg/dL	Optimal: < 150 Borderline: 150 - 199 High: 200 - 499 Very High: >= 500

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Investigation	Observed Value	Unit	Biological Reference Interval

INTERPRETATION: The reference ranges are based on fasting condition. Triglyceride levels change drastically in response to food, increasing as much as 5 to 10 times the fasting levels, just a few hours after eating. Fasting triglyceride levels show considerable diurnal variation too. There is evidence recommending triglycerides estimation in non-fasting condition for evaluating the risk of heart disease and screening for metabolic syndrome, as non-fasting sample is more representative of the `usual_ circulating level of triglycerides during most part of the day.

HDL Cholesterol (Serum/*Immunoinhibition)*	**53.30**	mg/dL	Optimal(Negative Risk Factor): >= 60 Borderline: 50 - 59 High Risk: < 50
LDL Cholesterol (Serum/*Calculated)*	148	mg/dL	Optimal: < 100 Above Optimal: 100 - 129 Borderline: 130 - 159 High: 160 - 189 Very High: >= 190
VLDL Cholesterol (Serum/*Calculated)*	16.4	mg/dL	< 30
Non HDL Cholesterol (Serum/*Calculated)*	164.4	mg/dL	Optimal: < 130 Above Optimal: 130 - 159 Borderline High: 160 - 189 High: 190 - 219 Very High: >= 220

INTERPRETATION: 1.Non-HDL Cholesterol is now proven to be a better cardiovascular risk marker than LDL Cholesterol.
2.It is the sum of all potentially atherogenic proteins including LDL, IDL, VLDL and chylomicrons and it is the "new bad cholesterol" and is a co-primary target for cholesterol lowering therapy.

Total Cholesterol/HDL Cholesterol Ratio (Serum/*Calculated)*	4.1		Optimal: < 3.3 Low Risk: 3.4 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0 High Risk: > 11.0
Triglyceride/HDL Cholesterol Ratio (TG/HDL) (Serum/*Calculated)*	1.5		Optimal: < 2.5 Mild to moderate risk: 2.5 - 5.0 High Risk: > 5.0

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Investigation	Observed Value	Unit	Biological Reference Interval
LDL/HDL Cholesterol Ratio (Serum/*Calculated*)	2.8		Optimal: 0.5 - 3.0 Borderline: 3.1 - 6.0 High Risk: > 6.0

Glycosylated Haemoglobin (HbA1c)

HbA1C (Whole Blood/*HPLC*)	5.5	%	Normal: 4.5 - 5.6 Prediabetes: 5.7 - 6.4 Diabetic: >= 6.5

INTERPRETATION: If Diabetes - Good control : 6.1 - 7.0 % , Fair control : 7.1 - 8.0 % , Poor control >= 8.1 %

Estimated Average Glucose (Whole Blood)	111.15	mg/dL	

INTERPRETATION: Comments
HbA1c provides an index of Average Blood Glucose levels over the past 8 - 12 weeks and is a much better indicator of long term glycemic control as compared to blood and urinary glucose determinations.
Conditions that prolong RBC life span like Iron deficiency anemia, Vitamin B12 & Folate deficiency, hypertriglyceridemia,hyperbilirubinemia,Drugs, Alcohol, Lead Poisoning, Asplenia can give falsely elevated HbA1C values.
Conditions that shorten RBC survival like acute or chronic blood loss, hemolytic anemia, Hemoglobinopathies, Splenomegaly,Vitamin E ingestion, Pregnancy, End stage Renal disease can cause falsely low HbA1c.

THYROID PROFILE / TFT

T3 (Triiodothyronine) - Total (Serum/*Chemiluminescent Immunometric Assay (CLIA)*)	0.91	ng/ml	0.7 - 2.04

INTERPRETATION:
Comment :
Total T3 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T3 is recommended as it is Metabolically active.

T4 (Tyroxine) - Total (Serum/*Chemiluminescent Immunometric Assay (CLIA)*)	9.32	µg/dl	4.2 - 12.0

INTERPRETATION:
Comment :
Total T4 variation can be seen in other condition like pregnancy, drugs, nephrosis etc. In such cases, Free T4 is recommended as it is Metabolically active.

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Investigation	Observed Value	Unit	Biological Reference Interval
TSH (Thyroid Stimulating Hormone) (Serum/*Chemiluminescent Immunometric Assay (CLIA)*)	1.200	µIU/mL	0.35 - 5.50

INTERPRETATION:
Reference range for cord blood - upto 20
1 st trimester: 0.1-2.5
2 nd trimester 0.2-3.0
3 rd trimester : 0.3-3.0
(Indian Thyroid Society Guidelines)
Comment :
1.TSH reference range during pregnancy depends on Iodine intake, TPO status, Serum HCG concentration, race, Ethnicity and BMI.
2.TSH Levels are subject to circadian variation, reaching peak levels between 2-4am and at a minimum between 6-10PM.The variation can be of the order of 50%,hence time of the day has influence on the measured serum TSH concentrations.
3.Values&amplt;0.03 µIU/mL need to be clinically correlated due to presence of rare TSH variant in some individuals.

Urine Analysis - Routine

COLOUR (Urine)	Pale yellow		Yellow to Amber
APPEARANCE (Urine)	Clear		Clear
Protein (Urine/*Protein error of indicator*)	Negative		Negative
Glucose (Urine/*GOD - POD*)	Negative		Negative
Pus Cells (Urine/*Automated ¯ Flow cytometry)*	**2 - 3**	/hpf	NIL
Epithelial Cells (Urine/*Automated ¯ Flow cytometry)*	**1 - 2**	/hpf	NIL
RBCs (Urine/*Automated ¯ Flow cytometry)*	NIL	/hpf	NIL
Casts (Urine/*Automated ¯ Flow cytometry)*	NIL	/hpf	NIL
Crystals (Urine/*Automated ¯ Flow cytometry)*	NIL	/hpf	NIL

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Investigation	Observed Value	Unit	Biological Reference Interval
Others (Urine)	NIL		

INTERPRETATION: Note: Done with Automated Urine Analyser & Automated urine sedimentation analyser. All abnormal reports are reviewed and confirmed microscopically.

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-- End of Report --

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Name	Ms.RAMYA S	ID	MED112132425
Age & Gender	33/FEMALE	Visit Date	29/03/2024
Ref Doctor Name	MediWheel		

SONOGRAM REPORT

WHOLE ABDOMEN

The liver is normal in size and shows diffuse fatty changes. No focal mass seen.

The gall bladder is normal sized and smooth walled and contains no calculus.

There is no intra or extra hepatic biliary ductal dilatation.

The pancreas shows a normal configuration and echotexture.

The pancreatic duct is normal.

The portal vein and IVC are normal.

The spleen is normal.

There is no free or loculated peritoneal fluid.

No para aortic lymphadenopathy is seen.

No abnormality is seen in the region of the adrenal glands.

The right kidney measures 9.9 x 4.1 cms.

The left kidney measures 8.8 x 4.4 cms.

Both kidneys are normal in size, shape and position.

Cortical echoes are normal bilaterally.

There is no calculus or calyceal dilatation.

The ureters are not dilated.

Name	Ms.RAMYA S	ID	MED112132425
Age & Gender	33/FEMALE	Visit Date	29/03/2024
Ref Doctor Name	MediWheel		

The bladder is smooth walled and uniformly transonic. There is no intravesical mass or calculus.

The uterus is anteverted, and measures 10.4 x 4.4 cms. *The fundus is pulled up and is adherent to the anterior abdominal wall (Post LSCS).*

Myometrial echoes are homogeneous.

The endometrium measures 4.6 mm.

The right ovary measures 3.0 x 1.6 x 3.6 cms, Volume; 9.5 cc.

The left ovary measures 3.1 x 1.8 x 3.6 cms, Volume; 11.2 cc.

Both ovaries are mildly enlarged and shows multiple tiny cysts in the periphery.

Parametria are free.

Iliac fossae are normal.

No mass or fluid collection is seen in the right iliac fossa. The appendix is not visualized.

IMPRESSION:

- **Fatty liver.**
- **Pelvic adhesions (Post LSCS).**
- **Mildly polycystic ovaries.**

am **DR.**
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CONSULTANT RADIOLOGIST

REPORT DISCLAIMER

1.This is only a radiologincal imperssion.Like other investigations, radiological investication also have limitation. Therefore radiologincal reports should be interpreted in correlation with clinical and pathological findings.

2.The results reported here in are subject to interpretation by qualified medical professionals only.

3.Customer identities are accepted provided by the customer or their representative.

4.information about the customer's condition at the time of sample collection such as fasting, food consumption, medication, etc are accepted as provided by the customer or representative and shall not be investigated for its truthfulness.

5.If any specimen/sample is received from any others laboratory/hospital,its is presumed that the sample belongs to the patient identified or named.

6.Test results should be interpreted in context of clinical and other findings if any.In case of any clarification /doubt , the refrering doctor/patient can contact the respective section head of the laboratory.

7.Results of the test are influenced by the various factors such as sensitivity, specificity of the procedures of the tests, quality of the samples and drug interactions etc.,

8.If the test results are found not to be correlating clinically can contact the lab in charge for clarification or retesting where practicable within 24 hours from the time of issue of results.

9.Liability is limited to the extend of amount billed.

10.Reports are subject to interpretation in their entirety.partial or selective interpretation may lead to false opinion.

11.Disputes,if any , with regard to the report findings are subject to the exclusive jurisdiction of the competent courts chennai only.